STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445303	A. BUILDING _____ B. WING _____	12/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS HEALTH AND REHABILITATION CENTER	3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #30749, #30688, #30316, and #30185, were completed on November 26, 2012, through December 3, 2012. No deficiencies were cited related to complaint investigation #30316 and #30185. Deficiencies were cited related to complaint investigation #30749 and #30688 under CFR Part 483.13, Requirements for Long Term Care Facilities.	F 000	**F157** **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** MD of resident #119 was notified on 11/28/12 that the BMP ordered 11/15/12 was not obtained. Further orders were received and implemented on 11/28/12. Resident #4 no longer resides in the facility. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Residents with orders for labs have the potential to be affected. An audit of MD ordered labs will be conducted by members of nursing management (Director of Nursing, Staff Development Coordinator and Nursing supervisor) to identify if any labs were missed to assure timely notification of the MD. This will be completed on 12/14/2012 Residents with wounds have the potential to be affected. An audit of residents with wounds will be conducted by members of nursing management to determine	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michell Brakebill Wilkerson — TITLE: Admin Director — (X6) DATE: 12/17/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to notify the physician laboratory tests were not completed as ordered by the physician for one (#119), and failed to notify the resident's family of a medical procedure for one (#4) of forty-one residents reviewed. The findings included: Resident #119 was admitted to the facility on January 13, 2012, with diagnoses including Cerebrovascular Accident, Hypertension, Depression, and Psychosis. Medical record review of a physician's order dated November 15, 2012, revealed "...BMP (Basic Metabolic Profile) stat (immediately)..." Medical record review revealed no laboratory results for the BMP on November 15, 2012. Review of facility policy, Laboratory Management, revealed "...Daily reconciliation by a designated Licensed Nurse to validate that the attending physicians that ordered the lab tests have been notified timely of the results..." Interview on November 28, 2012, at 4:05 p.m.,	F 157	if a debridement procedure has been performed by the MD to assure that family/responsible party was notified. This was completed on 12/14/12 **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** The Staff Development Coordinator (SDC)and members of nursing management will educate licensed nurses regarding notification of the physician when a lab is not obtained as ordered by the MD. Education will be complete by 12/22/12. Any nurse not completing education will be educated prior to their next scheduled shift. On 12/12/12 the Medical Director and the Director of Nursing were educated by the Regional Clinical Director regarding the notification of family/responsible party for debridement of wounds. Members of nursing management will reconcile MD ordered labs daily Monday – Friday and by a charge nurse on the weekend when applicable. If any lab is determined to have been missed, the MD will be notified when identified for further orders.	

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F 157	Continued From page 2 with the Director of Nursing, in the Staff Development Office, confirmed the BMP was not obtained on November 15, 2012, as ordered by the physician, and the physician was not notified until today (November 28, 2012). Resident #4 was admitted to the facility on September 10, 2012, with diagnoses including Anoxic Brain Injury, Respiratory Failure, Paraplegia, Chronic Obstructive Pulmonary Disease, Neurogenic Bladder, History of Hepatitis C, Osteomyelitis, Seizure Disorder, and Pressure Ulcers. Medical record review of the admission Minimum Data Set dated September 17, 2012, revealed the resident had short and long term memory problems, and severely impaired cognitive skills. Medical record review of the Weekly Pressure Ulcer Record dated September 11, 2012, revealed the resident was admitted with an unstageable wound on the coccyx measuring 9.0 cm. (centimeters) x 14.0 cm. x 0.5 cm. Medical record review of a physician's note dated September 26, 2012, revealed "...I was on wound rounds to inspect the sacrum which had begun to open...sacral pressure ulcer Stage IV. The dark leathery eschar deteriorated to liquid beneath so some eschar was sharp debrided (the removal of dead or damaged tissue). Continue current treatment orders BID (twice a day)...Summary: Sharp debrided black eschar revealing liquid necrotic black discharge and soft material. Cleanse, santyl, 1/4 strength Dakins, wet to dry, cover BID."	F 157	When MD determines that debridement of wound is necessary, the family/ responsible party will be notified of procedure. Members of nursing management will audit 10% of charts of residents with lab orders to assure that the MD has been notified timely of any missed lab. This will occur weekly for 4 weeks then monthly for 2 additional months for a total of 3 months. Members of nursing management will review wound documentation weekly for 4 weeks, then monthly for 2 additional months to assure that appropriate notification of family/responsible occurred appropriately if debridement of a wound was performed. **How will facility monitor its corrective actions to ensure that the deficient practice will not recur?** Results of the audits will be presented to the Quality Assurance Performance Improvement Committee (QAPI) by the Director of Nursing/designee for a period of three months or until substantial compliance is determined by the QAPI Committee. **Date of compliance:** 01/02/13.	

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F 157	Continued From page 3 Medical record review revealed no documentation the resident's family was notified of the debridement procedure. Interview on November 29, 2012, at 2:05 p.m., with the physician, in the Director of Nursing's office, confirmed the resident's family was not notified of the debridement performed on September 26, 2012. C/O #30688	F 157	**F281** **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident #154 Vitamin D2 50,000 unit's orders were clarified with the MD on 12/11/12.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's orders for one resident (#154) of forty-one residents reviewed. The findings included: Resident #154 was admitted to the facility on November 9, 2012, with diagnoses including Pneumonia, Diabetes, Congestive Heart Failure, and Atrial Fibrillation. Medical record review of physician orders dated November 9, 2012, revealed the resident was to receive Vitamin D2 50,000 units once a month on Mondays.	F 281	**How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Residents requiring monthly medications have the potential to be affected by this alleged deficient practice. Residents with monthly medication orders were reviewed to assure proper administration per the MD order. This was completed on 12/13/12 **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** Licensed Nurses will be educated by the Staff Development Coordinator/members of nursing management on the proper administration of monthly medications.	

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F 281	Continued From page 4 Medical record review of the November 2012, Medication Record revealed the Vitamin D2 50,000 units was administered on November 19 and 26, 2012. Interview on November 29, 2012, at 8:39 a.m., with Licensed Practical Nurse #3, at the nursing station, confirmed the physician's orders were not followed.	F 281	This will be completed by 12/22/12. Any licensed nurse not completing the education will be educated prior to next scheduled shift. Members of nursing management will audit 10% of residents with monthly medication orders weekly for 4 weeks then monthly for 2 additional months to assure proper administration as ordered by the MD. **How will facility monitor its corrective actions to ensure that the deficient practice will not recur?** Results of the audits will be presented to the Quality Assurance Performance Improvement Committee (QAPI) by the Director of Nursing/designee for a period of three months or until substantial compliance is determined by the QAPI Committee. **Date of compliance**:01/02/2013	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation, observation, and interview, the facility failed to ensure a safety device was in place for one (#134) of forty-one residents reviewed. The findings included: Resident #134 was admitted to the facility on October 3, 2012, with diagnoses including Pneumonia, Neuropathy, Senile Dementia, Hypertension, and Anemia. Medical record review of a fall risk assessment dated October 10, 2012, revealed the resident	F 323	**F323** **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**	

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F 323	Continued From page 5 was at high risk for falls. Medical record review of the care plan dated October 11, 2012, revealed "...Chair alarm 10/13/12 (clip) 11/15/12 (pressure pad)..." Review of the facility investigation dated November 22, 2012, revealed "...(resident) was sitting in w/c (wheelchair) in room when last observed at 11:20 am. At 11:55 am res. (resident) states...got tired of sitting and stood up. Res. states feet got caught in w/c pedals and...fell against closet door and slid to floor...(no injury) Res has chair alarm and pressure pad which were not attached to resident...staff educated about placement of bed/chair alarms and pressure pads..." Observation on November 28, 2012 at 8:45 a.m., revealed the resident seated in a w/c in the resident's room with a pressure pad alarm. Interview on November 28, 2012, at 11:30 a.m., with the Director of Nursing, in the Staff Development Office, confirmed the alarm was not in place at the time of the fall on November 22, 2012.	F 323	On 12/11/12 resident #134 was observed by the Director of Nursing to have personal alarm in place per the resident's care plan. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Residents with personal alarms have potential to be affected. Residents with personal alarms ordered were observed to assure that the alarms were in place per the care plan. This will be completed by: 12/13/2012 **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?**	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy	F 502	The Staff Development Coordinator and members of nursing management will educate licensed nurses and resident care specialist (Certified Nursing Assistants) regarding placement of personal alarms per the residents care plan. Education will be completed by 12/22/12. Licensed nurses and resident care specialist who do not complete the education will be educated prior to next scheduled shift.	

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F 502	Continued From page 6 review, and interview, the facility failed to obtain laboratory tests as ordered by the physician for one (#119) of forty-one residents reviewed. The findings included: Resident #119 was admitted to the facility on January 13, 2012, with diagnoses including Cerebrovascular Accident, Hypertension, Depression, and Psychosis. Medical record review of a physician's order dated November 9, 2012, revealed "...(increase) Lasix to 40 mg (milligrams) 1 po (by mouth) BID (twice a day)...BMP (Basic Metabolic Profile) on 11/12/12..." Medical record review revealed no laboratory results for the BMP on November 12, 2012. Medical record review of the physician's progress notes dated November 13, 2012, revealed "...BMP pending-was drawn this AM but rejected by lab (increase) Lasix 60 mg q (every) AM, cont (continue) 40 mg PM..." Medical record review of a physician's order dated November 15, 2012, revealed "...BMP stat (immediately)..." Medical record review revealed no laboratory results for the BMP on November 15, 2012. Review of the facility policy, Laboratory Management, revealed "...Daily reconciliation at a consistent time by a designated Licensed Nurse/designee to validate that requested labs were ordered and obtained by checking the	F 502	Members of nursing management will audit 10% of residents with alarms daily (Monday-Friday) to ensure placement per the resident plan of care weekly for 4 weeks then monthly for 2 additional months to assure alarm placement per the resident's care plan. Ambassadors will observe residents who have personal alarms for placement per the residents care plan Monday-Friday. **How will facility monitor its corrective actions to ensure that the deficient practice will not recur?** Results of the audits will be presented to the Quality Assurance Performance Improvement Committee (QAPI) by the Director of Nursing/designee for a period of three months or until substantial compliance is determined by the QAPI Committee. **Date of compliance: 01/02/2013** **F502** **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**	

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F 502	Continued From page 7 documentation in the Laboratory Request Log Book or designated record..." Interview on November 28, 2012, at 1:30 p.m., with the Director of Nursing, in the Staff Development Office, confirmed the BMP was not obtained on November 12, 2012, as ordered by the physician. Interview on November 28, 2012, at 4:05 p.m., with the Director of Nursing, in the Staff Development Office, confirmed the BMP was not obtained on November 15, 2012, as ordered by the physician.	F 502	On November 28th, 2012 a BMP was obtained for resident #119 and the Physician was notified of the results on November 28th, 2012. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Residents who have orders for labs have the potential to be affected.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain complete medical records for four residents (#4, #42, #100, #80) of forty-one residents reviewed.	F 514	Members of Nursing management will audit charts of current residents who have MD orders for labs to determine if labs have been obtained per MD orders. This will be complete by 12/14/2012 **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** The Staff Development Coordinator/members of nursing management will educate licensed nurses regarding obtaining labs per MD order. Licensed nurses will be educated on the daily reconciliation of labs process to assure the completion per MD order. Education will be completed by 12/22/12. Licensed Nurses who do not complete the education will be educated prior to their next scheduled shift.	

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F 514	Continued From page 8 The findings included: Resident #4 was admitted to the facility on September 10, 2012, with diagnoses including Anoxic Brain Injury, Respiratory Failure, Paraplegia, Chronic Obstructive Pulmonary Disease, Neurogenic Bladder, History of Hepatitis C, Osteomyelitis, Seizure Disorder, and Pressure Ulcers. Medical record review of a physician's order dated September 12, 2012, revealed "Treatment order sacral ulcer Stage IV cleanse, pat dry, apply Santyl, cover with ¼ strength Dakins on gauze, cover with absorbent dressing and change dressing twice a day..." Medical record review of the September 10-30, 2012, Treatment Record revealed no documentation treatment was provided to the sacral ulcer on the 2:00 p.m., until 10:00 p.m., shift on September 16, 19, 20, 21, and 25, 2012. Interview on November 29, 2012, at 2:50 p.m., with Licensed Practical Nurse (LPN) #2 in the Staff Development Office, revealed LPN #2 was responsible for the wound care on the 2:00 p.m., until 10:00 p.m., shift, on September 16, 19, 20, 21, and 25, 2012. Continued interview revealed LPN #2 had completed the wound care on September 16, 19, 20, 21, and 25, 2012, however, confirmed there was no documentation the wound care was completed. Resident #42 was admitted to the facility on March 8, 2006, with diagnoses including Cerebrovascular Accident, Hypothyroidism, and	F 514	Members of nursing management audit the laboratory reconciliation logs daily (Monday-Friday) for 4 weeks, then monthly for 2 additional months. An ongoing process of lab review will be incorporated into the morning clinical meeting Monday – Friday. **How will facility monitor its corrective actions to ensure that the deficient practice will not recur?** Results of the audits will be presented to the Quality Assurance Performance Improvement Committee (QAPI) by the Director of Nursing/designee for a period of three months or until substantial compliance is determined by the QAPI Committee. **Date of compliance**01/02/2013 **F514** **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident #4 no longer resides in the facility.	

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F 514	Continued From page 9 Anxiety. Medical record review of the Meal Detail Report revealed no documentation the resident accepted or refused hs (bedtime) snacks on November 4, 11, 16, 21, 23, 24, and 25, 2012. Interview on December 3, 2012, at 1:30 p.m., with the Director of Nursing (DON), in the Staff Development Office, confirmed no documentation the resident accepted or refused hs snacks on November 4, 11, 16, 21, 23, 24, and 25, 2012. Resident #100 was admitted to the facility on July 30, 2012, with diagnoses including Rhabdomolysis, Anemia, and Morbid Obesity. Review of the Meal Detail Report revealed no documentation the resident accepted or refused hs snacks on November 11, 16, 21, 23, 24, and 25, 2012. Interview on December 3, 2012, at 1:30 p.m., with the DON, in the Staff Development Office, confirmed no documentation the resident accepted or refused hs snacks on November 11, 16, 21, 23, 24, and 25, 2012. Resident #80 was admitted to the facility on August 9, 2010, with diagnoses including Chronic Pain Syndrome, Anxiety, and Hypertension. Review of the Meal Detail Report revealed no documentation the resident accepted or refused hs snacks on November 21, 23, 24, and 25, 2012. Interview on December 3, 2012, at 1:30 p.m., with	F 514	Residents #42, #100, #80 are now being offered snacks nightly and acceptance or refusals are being documented by nursing staff in Caretracker. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Residents with wound treatment orders have potential to be affected by this alleged deficient practice. An audit of December 2012 TARs of current residents with wound treatment orders was conducted by members of nursing management to determine any failure to document the wound treatment. This will be completed by 12/17/2012 Residents that are not NPO have potential to be affected by this alleged deficient practice. An audit of HS snack documentation in Caretracker was conducted by members of nursing manage to determine any failure to document the acceptance or refusal of the HS snack. This will be completed by .	

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F 514	Continued From page 10 the DON, in the Staff Development Office, confirmed no documentation the resident accepted or refused hs snacks on November 21, 23, 24, and 25, 2012. C/O #30749 C/O #30688	F 514	**What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** The Staff Development Coordinator/members of nursing management will educate licensed nurses regarding the required documentation for residents with orders for wound treatments. This will be complete by 12/22/12. Licensed nurses who do not complete the education will be educated prior to their next scheduled shift. The Staff Development Coordinator/members of nursing management will educate licensed nurses and resident care specialist regarding the documentation requirement of HS snack delivery. Licensed nurses and resident care specialist who do not complete the education will be educated prior to next scheduled shift. . Members of nursing management will audit treatment administration records of 10% of residents with wound treatment orders daily (Monday-Friday) to determine if any treatments done were failed to be documented. The licensed nurse responsible will be contacted for clarification. This will occur weekly for 4 weeks then monthly for 2 additional months.	

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